NC DMA Pharmacy Request for Prior Approval
Fasenra

DMA-3610

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name: _____
3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth:_____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information
   Name:_____ Phone #:_____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength:_____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

For initial therapy:
Asthma (answer questions 1-10)

1. Is the beneficiary age 12 or greater? Yes____ No____
2. Does the beneficiary have a diagnosis of severe asthma with an eosinophilic phenotype? Yes____ No____
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Fasenra) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? Yes____ No____ Please list eosinophil count_____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? Yes____ No____
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? Yes____ No____ Please List:_____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes____ No____
   Please List FEV1 value_____
7. Is Fasenra being used as add on maintenance treatment? Yes____ No____
8. Is Fasenra being used for the treatment of other eosinophilic conditions? Yes____ No____
9. Is Fasenra being used for the relief of acute bronchospasm or status asthmaticus? Yes____ No____
10. Is Fasenra being used as dual therapy with other monoclonal antibody treatments? Yes____ No____

For continuation of therapy:
Asthma (answer question 11)

11. Has the beneficiary experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Fasenra treatment?

    Yes____ No____ **Please attach medical records to this request.

Signature of Prescriber: _____
* Prescriber Signature mandatory

Date_____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505